FIREFIGHTERS CANCER PRESUMPTION

1. Summary of Chapter 1568, Statutes of 1982

On February 23, 1984 the Board of Control (successor agency is the Commission On State Mandates) determined that fire departments will incur "costs mandated by the state" as a result of Chapter 1568 of the Statutes of 1982, which added Section 3212.1 to the Labor Code and that such costs are reimbursable pursuant to Government Code Section 17561. This section states that cancer that has developed or manifested itself in peace officers will be presumed to have arisen out of and in the course of employment, unless the presumption is controverted by other evidence. The presumption is extended to a peace officer following termination of service for a period of three calendar months for each year of requisite service, but not to exceed sixty (60) months in any circumstance, commencing with the last date actually worked in the specified capacity.

2. Eligible Claimants

Any fire department of a city, a county, a city and county, a local fire prevention district, a public municipal corporation or political subdivision of the state that employs firefighters and incurs increased costs as a result of this mandate is eligible to claim reimbursement of those costs.

3. Type of Claims

A. Reimbursement Claims

A reimbursement claim is defined in GC Section 17522 as any claim filed with SCO by a county for reimbursement of costs incurred for which an appropriation is made for the purpose of paying the claim.

An actual claim may be filed by February 15 following the fiscal year in which costs were incurred. If the filing deadline falls on a weekend or holiday, the filing deadline will be the next business day. Since the 15th falls on a weekend in 2009 claims for fiscal year 2007-08 will be accepted without penalty if postmarked or delivered on or before February 17, 2009. Claims filed after deadline will be reduced by a late penalty of 10%, not to exceed $10,000. A claim filed more than one year after the deadline cannot be accepted for reimbursement.

In order for a claim to be considered properly filed, it must include the Indirect Cost Rate Proposal (ICRP) if the indirect cost rate exceeds 10%. A more detailed discussion of the ICRP may be found in Section 8 of the instructions.

Documentation to support actual costs must be kept on hand by the claimant and made available to the SCO upon request as explained in Section 17 of the instructions.

B. Estimated Claims

Pursuant to AB 8, Chapter 6, Statutes of 2008, the option to file estimated claims has been eliminated. Therefore, estimated claims filed on or after February 16, 2008, will not be accepted by SCO.Reimbursement

4. Reimbursements

Eligible claimants will be reimbursed at fifty percent (50%) of costs incurred as defined as follows:

A. All the following conditions must be met in order to claim reimbursement for a

presumption of cancer case under Chapter 1171/89.

(1) The worker is a fire fighter within the meaning of Penal code Section 830.1 who was primarily engaged in active law enforcement activities;

(2) The worker has cancer which has caused the disability;

(3) The worker's cancer developed or manifested itself during a period while the worker was in the service of the employer, or within the extended period provided for in Labor Code Section 3212.1;

(4) The worker was exposed, while in the service of the employer, to one or more known carcinogens as defined by the International Agency for Research on Cancer, or the Director of the Department of Industrial Relations; and

(5) The one or more carcinogens to which the worker was exposed are reasonable linked to the disabling cancer, as demonstrated by competent medical evidence.

B. A case meeting all the conditions in 5.A., the local agency will be reimbursed at 50% of the increased costs incurred. More specifically, insured local agencies, local agencies covered by a joint powers agreement, or self-insured local agencies must claim costs as follows:

(1) Insured Local Agencies

If an insured local agency (insured through State Compensation Insurance Fund) incurred any increased costs as a result of Chapter 1586/82, they would be entitled to seek reimbursement for such costs that are specifically attributable to Labor Code Section 3212.1.

If the local entity can show that its experience modification premium was increased or its dividends were decreased, 50% of those respective increases or decreases will be reimbursed.

(2) Local Agencies Covered by a Joint Powers Agreement or Other Carrier:

Local agencies covered by a joint powers agreement or other insurance carrier for workers' compensation may claim in the same manner as above for insured local agencies provided;

a. Insurance premiums or contributions are based on the Workers' Compensation Insurance Rating Bureau rates and the current loss experience modification factor, and

b. The insurer is responsible for claims of terminated or withdrawn local agencies if such claims arose while insured by the insurer.

(3) Self-insured Local Agencies:

Fifty percent (50%) of all actual costs of a claim based on the presumption set forth in Labor Code Section 3212.1 are reimbursable, including but not limited to the following:

1. Administrative Costs

Salaries and employee benefits, costs of supplies, legal counsel costs, clerical support, travel expenses, amounts paid to adjusting agencies, overhead costs

2. Benefit Costs

   Actual benefit costs under this presumption shall be 50% reimbursable and shall include, but are not limited to:

   Permanent disability benefits, death benefits, temporary disability benefits or full salary in lieu of temporary disability benefits as required by Labor Code Section 4850, or other local charter provision or ordinance in existence on January 1, 1983. Provided, however, that salary in lieu of temporary disability benefits were payable under local charter provision or ordinance shall be reimbursable only to the extent that those benefits do not exceed the benefits required by Labor Code Section 4850.

5. **Reimbursement Limitations**

   Any offsetting savings the claimants experience as a direct result of this statute must be deducted from the cost claimed. Such offsetting savings shall include, but not be limited to, savings in the cost of personnel, service or supplies, or increased revenues obtained by the claimant. In addition, reimbursements received from any source (e.g., federal, state, etc.) for this mandate shall be identified and deducted from the claim.

6. **Claiming Forms and Instructions**

   The diagram "Illustration of Claim Forms" provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for forms FCP-1.1 or FCP-1.2, FCP-2.1 and FCP-2.2, provided the format of the report and data fields contained with the report are identical to the claim forms included in these instructions. The claim forms provided in this chapter should be duplicated and used by the claimant to file a reimbursement claim. The State Controller's Office will revise the manual and claim forms as necessary.

   A. Form FAM-27, Claim for Payment

   This form contains a certification that must be signed by an authorized representative for the local agency. All applicable information from form FCP-1.1 or FCP-1.2 must be carried forward to this form in order for the State Controller's Office to process the claim for payments.

   B. Form FCP-1.1, Claim Summary

   An insured agency must complete this form that shows the increased premium cost and/or decreased dividend cost. In addition, show the names of each injured peace officer, termination date of service, length of service (years and months), and date of injury. The increased costs derived from this form are carried to form FAM-27, line (13) for the Reimbursement Claim or line (07) for the Estimated Claim.

   C. Form FCP-1.2 Claim Summary

   A self-insured agency must complete this form that summarizes the increased disability benefit and administrative costs incurred as a result of the mandate. Allowable indirect costs for administrative costs are computed on this form. In addition, show the names of each injured fire fighter, termination date of service, length of service (years and months), and date of injury. The direct costs summarized on this form are carried forward from forms FCP-2.1 and FCP-2.2. Total cost derived on this form is carried forward to form FAM-27, line (13) for the Reimbursement Claim or line (07) for the Estimated Claim.

Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is reporting costs, each must have their own ICRP for the program.

D. Forms FCP-2.1 Component/Activity Cost Detail

A self-insured agency must complete this form that shows the amount of disability benefit payments made to peace officers as required by Labor Code Section 4850, or other charter provision or ordinance in existence on January 1, 1983.

E. Form FCP-2.2 Component/Activity Cost Detail

A self-insured agency must complete this form to claim increased administrative costs as a result of the mandate. Costs reported on this form must be detailed as follows:

(1) Salaries and Benefits

Identify the employee(s), and/or show the classification of the employee(s) involved. Describe the mandated functions performed by each named employee or classification and specify the actual number of hours devoted to each function, the productive hourly rate, and the related fringe benefits.

Source documents required to be maintained by the claimant may include, but are not limited to, employee time records that show the employees' actual time spent on the mandate.

(2) Services and Supplies

Only expenditures that can be identified as a direct cost of the mandate can be claimed. List cost of materials that have been consumed or expended specifically for the purpose of this mandate.

Source documents required to be maintained by the claimant may include, but are not limited to, invoices, receipts, purchase orders, and other documents evidencing the validity of the expenditures.

(3) Consultant Services

Give the name(s) of contractor(s) who performed the service. Describe the activities performed by each named contractor. Specify the actual hours spend on mandated activities, the inclusive dates when services were performed and itemize all costs of services performed. Attach consultant invoices with the claim.

Source documents required to be maintained by the claimant may include, but are not limited to, consultant contracts, invoices, receipts, purchase orders, and other documents evidencing the validity of the expenditures.

(4) Travel and Transportation

Travel expenses for mileage, per diem, lodging and other employee entitlement are reimbursable in accordance with the rules of the local jurisdiction. Give the name(s) of traveler(s), purpose of travel, inclusive travel dates, destination points

and travel costs.

Source required to be maintained by the claimant may include, but are not limited to, receipts, employee's travel expense claims, and other documents evidencing the validity of the expenditures.

For audit purposes, all support documents for actual costs must be retained for a period of four years after the end of the calendar year in which the reimbursement claim is filed or last amended. Such documents shall be made available to the State Controller's Office on request.

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
FIREFIGHTERS' CANCER PRESUMPTION

For State Controller Use Only	Program
(19) Program Number 00023	023
(20) Date Filed ____/____/____	
(21) LRS Input ____/____/____	

LABEL HERE

(01) Claimant Identification Number

(02) Claimant Name

County of Location

Street Address or P.O. Box Suite

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) **20___/20___**	(12) **20___/20___**
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Prior Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data	
(22) FCP-1.1, (05)(3)	
(23) FCP-1.1, (06)(3)	
(24) FCP-1.2, (04)(1)(d)	
(25) FCP-1.2, (04)(2)(d)	
(26) FCP-1.2, (05)	
(27) FCP-1.2, (06)	
(28) FCP-1.2, (07)	
(29) FCP-1.2, (08)	
(30) FCP-1.2, (09)	
(31) FCP-1.2, (10)	
(32)	
(33)	
(34)	
(35)	
(36)	

(37) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code §17561, I certify that I am the officer authorized by the local agency to file mandated cost claims with the State of California for this program, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1098, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein, and such costs are for a new program or increased level of services of an existing program. All offsetting savings and reimbursements set forth in the Parameters and Guidelines are identified, and all costs claimed are supported by source documentation currently maintained by the claimant.

The amounts for this Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs set forth on the attached statements. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature of Authorized Officer Date

Type or Print Name Title

(38) Name of Contact Person for Claim

Telephone Number **( ) - Ext.**

E-Mail Address

Program 023	FIREFIGHTERS' CANCER PRESUMPTION Certification Claim Form Instructions	FORM FAM-27

(01) Enter the payee number assigned by the State Controller's Office.

(02) Enter your Official Name, County of Location, Street or P. O. Box address, City, State, and Zip Code.

(03) If filing an estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing a combined estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended estimated claim, enter an "X" in the box on line (05) Amended.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of the estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form FCP-1.1 or FCP-1.2, as applicable, and enter the total claimed amount. If more than one form is completed due to multiple department involvement in this mandate, add the total claimed amounts from each form as applicable.

(08) Enter the same amount as shown on line (07).

(09) If filing a reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing a combined reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended reimbursement claim, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of the reimbursement claim from forms FCP-1.1 and FCP-1.2, lines (10) and (11), respectively. The total claimed amount must exceed $1,000.

(14) Reimbursement claims must be filed by January 15 of the following fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter zero if the claim was timely filed, otherwise, enter the product of multiplying line (13) by the factor 0.10 (10% penalty), or $1,000, whichever is less.

(15) If filing a reimbursement claim and a claim was previously filed for the same fiscal year, enter the amount received for the claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16), Net Claimed Amount, is positive, enter that amount on line (17), Due from State.

(18) If line (16), Net Claimed Amount, is negative, enter that amount in line (18), Due to State.

(19) to (21) Leave blank.

(22) to (36) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (36) for the reimbursement claim, e.g., FCP-1.1, (05)(03), means the information is located on form FCP-1.1, block (05), line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, i.e., no cents. Indirect costs percentage should be shown as a whole number and without the percent symbol, i.e., 35.19% should be shown as 35. **Completion of this data block will expedite the payment process**.

(37) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer, and must include the person's name and title, typed or printed. **Claims cannot be paid unless accompanied by an original signed certification**. **(To expedite the payment process, please sign the form FAM-27 with blue ink, and attach a copy of the form FAM-27 to the top of the claim package.)**

(38) Enter the name, telephone number, and e-mail address of the person to contact if additional information is required.

SUBMIT A SIGNED ORIGINAL, AND A COPY OF FORM FAM-27, WITH ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

Program 023	MANDATED COSTS FIREFIGHTERS CANCER PRESUMPTION CLAIM SUMMARY	FORM FCP-1.1

(01) Claimant	(02) Type of Claim	Fiscal Year
	Reimbursement ☐	
	Estimated ☐	20___/20___

Insured Method

(03) Firefighter Names	Service Termination Dates	Length of Service (Years/Months)	Dates of Injury

(04) Type of Insurance Carrier:

1. State Compensation Insurance Fund (SCIF) ☐
2. Joint Powers Agency (JPA) ☐ Name:
3. Private Insurance Carrier (PIC) ☐ Name:

	(a) SCIF	(b) JPA	(c) PIC
(05) Cost of Increased Experience Modified Premium:			
1. Actual Premium			
2. Increased Experience Modified Premium Percentage			
3. Increased Premium Cost			
(06) Cost of Decreased Dividends:			
1. Total Dividends			
2. Less: Dividends Received During the Fiscal Year			
3. Decreased Dividends			

(07) Total Increased Costs, Insured Method	[(Line (05)(3) + line (06)(3)]	

Cost Reduction

(08) Less: Offsetting Savings, if applicable		
(09) Less: Other Reimbursements, if applicable		
(10) Total Claimed Amount	[Line (07) - {line (08) + line (09)}] x 0.5	

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Program 023	FIREFIGHTERS CANCER PRESUMPTION CLAIM SUMMARY Instructions	FORM FCP-1.1

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year for which costs were incurred or are to be incurred.

Form FCP-1.1 must be filed for a reimbursement claim. Do not complete form FCP-1.1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form FCP-1.1 must be completed and a statement attached explaining the increased costs. Without this information the estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) List the name of each firefighter, service termination date, length of service (years/months), and date of injury. Only workers compensation filings subsequent to January 1, 1983 that are related to cancer and presumed to have arisen out of and in the course of employment qualify for reimbursement.

(04) Type of Insurance Carrier. Check a box to indicate if the claimant is insured with the State Compensation Insurance Fund (SCIF), a Joint Powers Agency (JPA), or a Private Insurance Carrier (PIC). If the claimant is insured by a JPA or a PIC, enter the name of the carrier.

For those who are insured by the SCIF, the SCIF will provide their clients with an appropriate modification factor and dividend amount for each applicable policy year upon written request to complete this schedule. Address: State Compensation Insurance Fund, Claims/Rehabilitation Department Operations, 1275 Market Street, San Francisco, CA 94103. In order for SCIF to provide this information, you must include with the request the above names and dates of injury. Please allow SCIF 30 days for this information. Normally, there is no impact on the modification factor until 18 to 24 months after injury. Following this period of time, the modification factor may be impacted for three consecutive policy years.

For those who are insured by a JPA or a private insurance carrier, claimants may wish to contact their insurance representative for assistance to determine what that lower experience modification premium percentage and total dividends would be had the agency not had any cancer presumption cases under Labor Code Section 3212.1. Attach a statement showing the calculations and any cost data provided by the insurance carrier.

(05) Cost of Increased Experience Modified Premium:

1. Enter the actual premium before the experience modified premium percentage was applied. Show the premium on a fiscal year basis and submit copies of billing statements with the claim. If necessary, prorate the premium amounts between the two policy years.
2. Enter the difference between the percentage that is shown on the final insurance premium billing statement and what the percentage would have been had there not been any cancer presumption cases under Labor Code Section 3212.1.
3. Multiply line (05)(1) by line (05)(2). If the premium was prorated, multiply each prorated portion by the modification percentage determined in line (05)(2), which relates to that portion of the premium. Show both calculations on a separate schedule.

(06) Cost of Decreased Dividends:

1. Enter the total dividends that would have been received for the fiscal year of cost had there not been any cancer presumption cases under Labor Code Section 3212.1.
2. Enter the dividends received during the fiscal year of cost.
3. Subtract the Dividends Received During the Fiscal Year of cost, line (06)(2), from the total Dividends, line (06)(1).

(07) Total Increased Cost. Multiply the sum lines (05)(3) and (06)(3).

(08) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a schedule of detailed savings with the claim.

(09) Less: Other Reimbursements, if applicable. Enter total other reimbursements received from any source, i.e., federal, other state programs, etc. Submit a schedule of detailed reimbursements with the claim.

(10) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (08), and Other Reimbursements, line (09), from Total Costs, line (07), and multiply by 0.5, since only 50% of the costs are reimbursable. Enter the result on this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

Program 023	MANDATED COSTS FIREFIGHTERS CANCER PRESUMPTION CLAIM SUMMARY	FORM FCP-1.2

(01) Claimant	(02) Type of Claim	Fiscal Year
	Reimbursement ☐	
	Estimated ☐	20___/20___

Self-Insured Method

(03) Firefighter Names	Service Termination Dates	Length of Service (Years/Months)	Dates of Injury

Direct Costs	**Object Accounts**			
(04) Reimbursable Components	(a) Salaries	(b) Benefits	(c) Services and Supplies	(d) Total
1. Disability Benefit Costs				
2. Administrative Costs				
(05) Total Direct Costs				

Indirect Costs		
(06) Indirect Cost Rate	[From ICRP]	%
(07) Total Indirect Costs	[Line (06) x line (05)(a)] or [line (06) x {line (05)(a) + line (05)(b)}]	
(08) Total Increased Costs, Self-Insured Method	[(Line (05)(d) + line (07)]	

Cost Reduction	
(09) Less: Offsetting Savings, if applicable	
(10) Less: Other Reimbursements, if applicable	
(11) Total Claimed Amount [Line (08) - {line (09) + line (10)}] x 0.5	

Program 023	FIREFIGHTERS CANCER PRESUMPTION CLAIM SUMMARY Instructions	FORM FCP-1.2

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year for which costs were incurred or are to be incurred.

Form FCP-1.2 must be filed for a reimbursement claim. Do not complete form FCP-1.2 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form FCP-1.2 must be completed and a statement attached explaining the increased costs. Without this information the estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) List the name of each firefighter, service termination date, length of service (years/months), and date of injury. Only workers compensation filings subsequent to January 1, 1983 that are related to cancer and presumed to have arisen out of and in the course of employment qualify for reimbursement.

(04) Reimbursable Components. For reimbursable component (04)(1), Disability Benefit Costs, enter Total Benefit Payments from form FCP-2.1, line (05)(h), to line (04)(1)(d) of this form.

For reimbursable component (04)(2), Administrative Costs, enter Total Administrative Costs from form FCP-2.2, line (05), columns (d), (e), and (f) to line (04)(2), columns (a), (b), and (c) of this form. Total each row.

(05) Total Direct Costs. Total columns (a) through (d) and enter on line (05).

(06) Indirect Cost Rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits, without preparing an ICRP. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim.

(07) Total Indirect Costs. If the 10% flat rate is used for indirect costs, multiply Total Salaries, line (05)(a), by the Indirect Cost Rate, line (06). If an ICRP is submitted and both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply the sum of Total Salaries, line (05)(a), and Total Benefits, line (05)(b), by the Indirect Cost Rate, line (06). If more than one department is reporting costs, each must have its own ICRP for the program.

(08) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (05)(d), and Total Indirect Costs, line (07).

(09) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(10) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source including, but not limited to, service fees collected, federal funds, and other state funds, which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(11) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (09), and Other Reimbursements, line (10), from Total Direct and Indirect Costs, line (08). Enter the remainder on this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

Program 023	**MANDATED COSTS FIREFIGHTERS CANCER PRESUMPTION COMPONENT/ACTIVITY COST DETAIL**	**FORM FCP-2.1**

(01) Claimant

(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Component: Disability Benefit Costs

(04) Description of Expenses: Complete columns (a) through (h).

(a) Employee Name	(b) Medical Expenses	(c) Temporary Disability Payments	(d) Permanent Disability Payments	(e) Life Pension	(f) Death Benefits	(g) Travel Expenses	(h) Total Benefit Payments

(05) Total ☐ Subtotal ☐ Page:____of____

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Program 023	FIREFIGHTERS CANCER PRESUMPTION COMPONENT/ACTIVITY COST DETAIL Instructions	FORM FCP-2.1

Note: This form is to be used in conjunction with form FCP-1.1.

(01) Enter the name of the claimant.

(02) Enter the fiscal year for which costs were incurred.

(03) Reimbursable Component: Disability Benefit Costs. This line identifies the costs that may be claimed on form FCP-2.1.

(04) In order to claim increased costs incurred for the fiscal year of the claim, the firefighter must meet the requirements as specified in Labor Code Section 3212.1.

(a) Enter the firefighter's name to which the disability benefits were paid.

(b) Enter all medical expenses paid for the firefighter.

(c) Enter temporary disability benefits or full salary paid in lieu of temporary disability benefits as required by Labor Code Section 4850, or other local charter provisions or ordinances that were in existence on January 1, 1983.

Provided, however, that salary in lieu of temporary disability benefits were payable under local charter provision or ordinance shall be reimbursable only to the extent that those benefits do not exceed the benefits required by Labor Code Section 4850.

(d) Enter all permanent disability benefits paid to the firefighter.

(e) Enter all life pension benefits paid to the firefighter.

(f) Enter all death benefits paid to the beneficiaries of the firefighter.

(g) Enter necessary and reasonable travel and related expenses paid to the firefighter.

(h) For each firefighter, total the benefit payments in columns (b) through (g).

(05) Add Total Benefit Payments, line (04), column (h), and enter the total on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component/activity costs, number each page. Enter the total from line (05), column (h) to form FCP-1.2, line (04)(1)(d).

Program 023	**MANDATED COSTS FIREFIGHTERS CANCER PRESUMPTION COMPONENT/ACTIVITY COST DETAIL**	**FORM FCP-2.2**

(01) Claimant	(02) Fiscal Year Costs Were Incurred
(03) Reimbursable Component: Administrative Costs	

(04) Description of Expenses: Complete columns (a) through (f).			**Object Accounts**		
(a) Employee Names, Job Classifications, Functions Performed, and Description of Services and Supplies	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Services and Supplies
(05) Total ☐ Subtotal ☐ Page:____of____					

Program 023	FIREFIGHTERS CANCER PRESUMPTION COMPONENT/ACTIVITY COST DETAIL Instructions	FORM FCP-2.2

Note: This form is to be used in conjunction with form FCP-1.2.

(01) Enter the name of the claimant.

(02) Enter the fiscal year for which costs were incurred.

(03) Reimbursable Component: Administrative Costs. This line identifies the costs that may be claimed on form FCP-2.2.

(04) Description of Expenses. Administrative costs incurred by self-insured agencies for processing cancer presumption case are reimbursable. The following table identifies the type of information required to support reimbursable costs. Enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, contract services, travel expenses, etc. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than three years after the date the claim was filed or last amended, whichever is later. If no funds were appropriated and no payment was made at the time the claim was filed, the time for the Controller to initiate an audit shall be from the date of initial payment of the claim. Such documents shall be made available to the State Controller's Office on request.

Object/ Sub object Accounts	Columns						Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	
Salaries	Employee Name Title Activities	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked			
Benefits		Benefit Rate		Salaries	Benefits = Benefit Rate x Salaries		
Services and Supplies Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity Used	
Contract Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service			Cost = Hourly Rate x Hours Worked or Total Cost	Invoice
Travel	Purpose of Trip Name and Title Departure and Return Date	Per Diem Rate Mileage Rate Travel Cost	Days Miles Travel Mode			Total Travel Cost = Rate x Days or Miles	

(05) Total line (04), columns (d), (e), and (f) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component/ activity costs, number each page. Enter the totals from line (05), columns (d), (e), and (f) to form FCP-1.2, line (04)(2).